PRINTED: 03/28/2012 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155704		(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING		(X3) DATE SURVEY COMPLETED 02/22/2012			
NAME OF PROVIDER OR SUPPLIER WALDRON HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182				
(X4) ID PREFIX TAG	SUMMARY STATEMEN (EACH DEFICIENCY MUST REGULATORY OR LSC IDEN	BE PERCEDED BY FULL	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
F0000	This visit was for Recer State Licensure Survey. Survey dates: February 2012 Facility Number: 00042 Provider Number: 1557 AIM Number: 1002904 Survey team: Barbara Hughes, RN, To Courtney Mujic, RN (Fe 2012) Beth Walsh, RN (February 2012) Karina Gates, HBS Census bed type: SNF/NF: 59 Total: 59 Census payor type: Medicare: 11 Medicaid: 41 6 Other: 7 Total: 59 Sample: 14 Supplemental sample: 2 This deficiency also reflections	19, 20, 21, 22, 23 704 250 C Ebruary 20, 21, 22, ary 20, 21, 22,	F0000	This Plan of Correction is the facility's credible allegation of compliance. Preparation and/or execution of the plan of correction does not constitute admission or agreement by the provider to the facts alleged or conclusions set forth in the statement of deficiencies. The plan of correction is prepared and/or executed solely because it is required by the provisions of federal and state law.			

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

Any defiency statement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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	OF CORRECTION	IDENTIFICATION NUMBER: 155704	(X2) MULTIPLE CC A. BUILDING B. WING	00	COMPI 02/22	
NAME OF PROVIDER OR SUPPLIER WALDRON HEALTH AND REHAB CENTER			STREET ADDRESS, CITY, STATE, ZIP CODE 505 N MAIN ST WALDRON, IN 46182			
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF COI (EACH CORRECTIVE ACTION S CROSS-REFERENCED TO THE DEFICIENCY)	HOULD BE	(X5) COMPLETION DATE
	REGULATORY OR cited in accordar	LSC IDENTIFYING INFORMATION) ace with 410 IAC 16.2. ompleted 2/28/12		CROSS-REFERENCED TO THE DEFICIENCY)	APPROPRIATE	

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Event ID: B2X611

Facility ID: 000423

If continuation sheet

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PRINTED: 03/28/2012 FORM APPROVED OMB NO. 0938-0391

	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING O COMPI	COMPLETED	
155704 B. WING	02/22/2012	
STREET ADDRESS, CITY, STATE, ZIP CODE		
NAME OF PROVIDER OR SUPPLIER 505 N MAIN ST		
WALDRON HEALTH AND REHAB CENTER WALDRON, IN 46182		
(X4) ID SUMMARY STATEMENT OF DEFICIENCIES ID	(X5)	
PROFILE (FACH DEFICIENCY MUST BE PERCEDED BY FULL) PREFIX (EACH CORRECTIVE ACTION SHOULD BE	COMPLETION	
TAG REGULATORY OR LSC IDENTIFYING INFORMATION) TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	DATE	
F0371 483.35(i)		
SS=F FOOD PROCURE,		
STORE/PREPARE/SERVE - SANITARY		
The facility must -		
(1) Procure food from sources approved or		
considered satisfactory by Federal, State or		
local authorities; and		
(2) Store, prepare, distribute and serve food		
under sanitary conditions Based on observation and interview the F0371 Tag Number F371 Food Procure.	03/23/2012	
Others (Desire and Architecture), the	03/23/2012	
the practice of this facility to:(1)		
holding temperatures were maintained, on Procure food from sources		
the kitchen steam table, throughout meal approved or considered		
service to the end of the meal service. satisfactory by Federal, State, or		
This had the potential to affect 52 out of local authorities; and(2) Store,		
50 residents who receive their mode		
under sanitary		
[Resident # 54] Resident's affected: The facility purchased new deeper steam		
table nane and dividere to ensure		
Findings include: maintaining correct food		
temperatures throughout meal		
On 2/20/12 at 12:10 p.m., food service. Dietary staff will be in		
temperatures were obtained from the serviced on storage, preparation,		
kitchen steam table, with the Dietary distribution, and the service of		
Manager as a series that had seed under sanitary conditions		
served. The pureed baked beans had a 3/8/12. The Dietary Manager/Designee will perform a		
temperature reading of 118 degrees tray audit weekly for 4 weeks and		
achieved		
temperature reading of 84 degrees ****Addendum**** compliance is		
Fahrenheit. defined as food temperatures		
consistenly being within		
On 2/22/12/ at 11:50 a.m., food requiatory guidelines. See		
temperatures were obtained from the		
steam table, with the Dietary Manager Manager/Designee will test the ground meat after one meal daily		
and the Regional Dietician, as soon as the for 4 weeks, weekly for 4 weeks,		
and the regional Bietician, as soon as the		

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Event ID: B2X611

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION		ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		a. building 00		00	COMPLETED	
155704		B. WIN			02/22/2012	
			B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	
NAME OF PROVIDER OR SUPPLIER					MAIN ST	
WALDRON HEALTH AND REHAB CENTER					RON, IN 46182	
					1	
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX	(EACH DEFICIENCY MUST BE PERCEDED BY FULL			PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)		_	TAG	•	DATE
		rved. The ground			compliance is achieved. See Attachment B1 All findings w	dill dill
	chicken had a ter	mperature reading of 119			be addressed immediately and	I
	degrees Fahrenh	eit.			included in the monthly QA	'
					meetings. Resident #54 was r	not
	In an interview v	with the Regional			harmed.Other Resident's	
		2/12 at 12:05 p.m., she			having the potential to be	
		olding temperatures for			affected: Although all residen	
		m table, need to be 135			have the potential to be affected	II
	-	eit or above throughout			by this alleged deficient praction please note that no adverse	ce,
	-	•			effects occurred by any	
	meal service to the end of meal service.				resident. Measures to ensure	
	The Dietary Manager also indicated that				practice does not reoccur: T	he
	food holding temperature, on the steam				facility purchased new deeper	
	table, should be	maintained at 135			steam table pans and dividers	to
	degrees Fahrenheit throughout the meal				ensure maintaining correct foo	
	service to the end of service.				temperatures throughout meal	
					service. Dietary staff will be in	
	During a group i	interview on 2/22/12 at			serviced on storage, preparation distribution, and the service of	I
	10:45 a.m., Resident #54 indicated that food is not always the appropriate temperature and it is cold when it should be warm, so sometimes they need to use a microwave to warm up the food.				food under sanitary conditions	I
					3/8/12. The Dietary	
					Manager/Designee will perforr	n a
					tray audit weekly for 4 weeks a	and
					then monthly until compliance	
					achieved. ***Addendum*** cor	npli
					ance is defined as food	_
	3.1-21(a)(2)				temperatures consistenly bein within regulatory guidelines.	~
					Attachment A1 The Dietary	
					Manager/Designee will test the	e
					ground meat after one meal da	
					for 4 weeks, weekly for 4 week	(S,
					and then monthly until	
					compliance is	t:
					achieved.***Addendum*** con	npii
					ance is defined as food temperatures consistently bein	
ı					within regulatory guidelines.	·
					Attachment B1 All findings w	I
					be addressed immediately and	

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Event ID: B2X611

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	OF CORRECTION	IDENTIFICATION NUMBER: 155704	A. BUILDING B. WING	00	COMPLETED 02/22/2012
	PROVIDER OR SUPPLIER		505 N I	ADDRESS, CITY, STATE, ZIP CODE MAIN ST RON, IN 46182	
(X4) ID PREFIX TAG	(EACH DEFICIEN	TATEMENT OF DEFICIENCIES CY MUST BE PERCEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
				included in the monthly QA meetings. This corrective action will be monitored by: The Dietary Manager/Designe will perform a tray audit week! 4 weeks and then monthly unt compliance achieved. See Attachment A1 The Dietary Manager/Designee will test the ground meat after one meal defor 4 weeks, weekly for 4 weel and then monthly until compliance is achieved. ***Addendum*** con ance is defined as food temperatures consistenly bein within requlatory guidelines. Attachment B1 All findings who be addressed immediately and included in the monthly QA meetings. Completion Date: 3/23/2012	y for il e aily ks, mpli g See

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 $\label{eq:local_problem} \mbox{If continuation sheet} \qquad \mbox{Page 5 of 5}$